

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUN 7 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2229

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
In this community 4 mo (Specify whether years, months or days)

3. (a) PRINT FULL NAME Wager, Charles C.

3. (b) If veteran, name was no

3. (c) Social Security No 491-14-2872

4. Sex M 0 5. Color or race W

6. (a) Single, widowed, married. 3 divorced Quaker

6. (b) Name of husband or wife unknown

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 26 - 1895
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 0 23 _____ hr. _____ min.

9. Birthplace Franklin Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Truck Driver

11. Industry or business _____

12. Name J. B. Reagan

13. Birthplace Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Gertrude Criss

15. Birthplace Penn
(City, town, or county) (State or foreign country)

16. (a) Informant W. C. Reagan

(b) Address 1940 E 71 Terr

17. (a) Burial (b) Date thereof May 21 - 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn Cem

18. (a) Signature of funeral director E. L. Clark

(b) Address 1800 Linwood

19. (a) 5-21-43 (b) M. M. Grove
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3401 Prospect
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19 year 1943 hour 10 minute 35 P. M.

21. I hereby certify that I attended the deceased from May 18 1943 to May 19 1943 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions Uremia
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

Means of injury _____

23. Signature Drury R. Thorne (M. D. or other) _____

Address _____

Date signed _____

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.